MIC CHOICE MN 750
Rx 25/65/80

MEDICA CHOICE
SUMMARY OF BENEFITS

City of St Paul
January 1, 2010
Group# 61652 and 16009

Partial Listing of Covered Services	Medica Choice In-Network Benefits	Out-of-Network Benefits*
Annual Deductible	$750 per member $1,500 per family	$1,000 per member $2,000 per family
Annual Out-of-Pocket Maximum	$3,000 per member	$3,000 per member
Lifetime Maximum	$5,000,000	
	When you receive covered services after the deductible has been met, the plan pays:	**When you receive covered services after the deductible has been met, the plan pays:**
Preventive Care	*The deductible does not apply to these services.*	
• Routine Physical & Eye Exams	100%	70%
• Immunizations, Well Child Care, Cancer Screenings and Allergy Shots	100%	70%
Office Visits		
• Illness or Injury	80%	70%
• Chiropractic Care	80%	70% *Limited to 15 visits per member, per year.*
• Physical, Occupational & Speech Therapy	80%	70%
• Mental Health and Substance Abuse	80% for individual therapy or 90% for group therapy.	70%
Prescription Drugs *Up to a 31-day supply per prescription*	*The deductible does not apply to these services.* Preferred Generic: 100% after $25 copayment Preferred Brand: 100% after $65 copayment Non-preferred: 100% after $80 copayment	60%. Member pays the greater of 40% or a $80 copayment per prescription unit.
Specialty Prescription Drugs *Up to a 31-day supply per prescription for specialty prescription drugs received from a designated specialty pharmacy.*	*The deductible does not apply to these services.* Preferred: 80%. Member does not pay more than $200 per prescription unit. Non-preferred: 60%	No Coverage
Inpatient Hospital Services		*Limited to 120 days per member, per year.*
• Facility	80%	70%
• Physician	80%	70%
• Mental Health and Substance Abuse	80%	70%
Outpatient Hospital Services		
• Facility	80%	70%
• Physician	80%	70%
Lab and Pathology	80%	70%
X-Ray and Other Imaging	80%	70%
Urgent or Emergency Care		
• Urgent Care Center	80%	80% after in-network deductible.
• Hospital Emergency Room	80%	80% after in-network deductible.
• Emergency Ambulance	80%	Covered as an in-network benefit
Durable Medical Equipment and Prosthetics	80%	70%
Home Health Care	80%	70%

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Out-of-Network Coverage

- Coverage is limited to the non-network provider reimbursement amount (as defined in your Certificate of Coverage) after deductible is met.
- If you decide to utilize your out-of-network benefits, you may pay more than you would for in-network benefits. The amount you pay could include a percentage coinsurance, a fixed dollar copayment and/ or deductible amount. In addition, if the amount that your non-network provider bills you is more than the non-network provider reimbursement amount (as defined in your Certificate of Coverage) **you are responsible for paying the difference,** and such difference will not be applied toward the out-of-pocket maximum.

Exclusions and Limitation to Coverage

The following is a list of some of the services and supplies that are excluded from coverage. When you enroll, the Certificate of Coverage you receive will provide a more complete and detailed list of exclusions. Please refer to your Certificate of Coverage for specific information about excluded services or supplies.

- Cosmetic Surgery
- Refractive Eye Surgery
- Exams for employment, insurance, administrative proceedings, research or licensure
- Personal convenience items and some non-durable supplies
- A drug, device, or medical treatment or procedure that is investigative or not a covered health service
- Custodial supportive care and self-care or self-help training
- Educational classes, programs or seminars
- Services prohibited by law or regulation
- Services for which coverage is available under worker's compensation, employer liability or any similar law

Contact **Customer Service at 952-945-8000** (Minneapolis/ St. Paul metro area), **952-992-3190** (Minneapolis/ St. Paul metro area individuals with hearing impairments), **800-952-3455** (outside of Minneapolis/ St. Paul metro area), or **800-841-6753** (outside of Minneapolis/ St. Paul metro area individuals with hearing impairments) for more information or answers to specific questions.

This health care plan is administered by Medica Insurance Company (MIC). It may not cover all your health care expenses; read your Certificate of Coverage carefully to determine which expenses are covered. This is a benefit summary only and does not outline all of your benefits. If there is a discrepancy between information in this summary and your Certificate of Coverage, the Certificate of Coverage will take precedence in determining your benefits.

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